

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8-9 yrs.
Hospital, institution, or street address where death occurred:
Public place
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

John W. Bair

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Alberta

7. Birth date of deceased (mo., day, yr.) June 20, 1896 6.(c) If alive, give age — years

8. AGE: Years 51 Months 2 Days 25 If less than one day — hrs. — min.

9. Birthplace Strasburg Penn.
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business —

12. Name John Bair

13. Birthplace Strasburg Penn.

14. Maiden name Bessie Mitchell

15. Birthplace Penn.

16. Informant Mrs. Alberta Bair

Address Bel Air, Md.

17. Burial Date thereof 9/18/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Strasburg Penn.

Location Hunt & Ryan

18. Funeral director Waldorf & Co.

Address La Plata, Md.

19. 9-16 19-47 Julius H. Perry
(Date rec'd by registrar) (Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1947 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on
Sept. 15, 1947 — —
and that I did saw h. — on — —

Immediate cause of death Probably, coronary occlusion
Due to Coronary artery disease
Due to Diabetes mellitus
Other conditions Chronic alcoholism

DURATION
10-15'

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE John L. MacKinnon, M.D. M. D. or other

Address La Plata, Md. Date signed 9-15-47

MARGIN RESERVED FOR BINDING

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9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 26 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07940 105

1. PLACE OF DEATH:

County Charles
 City or town Bryantown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Charles
 City or town Bryantown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Richard Bowling

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Margaret S. Bowling7. Birth date of deceased (mo., day, yr.) Feb. 7, 1867 6.(c) If alive, give age _____ years8. AGE: Years 80 Months 7 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Bryantown, Md.
(Town, county, and state)10. Usual occupation (Retired) Farmer

11. Industry or business

12. Name Benjamin F. Bowling
13. Birthplace Chas. Co. Md.14. Maiden name Mary Emily Morton
15. Birthplace Md.16. Informant William F. Bowling
Address Bryantown, Md.17. (Burial, cremation, or removal, which?) Burial Date thereof 9/10/47
(month) (day) (year)18. Cemetery or crematory St. Mary's
Location Bryantown, Md.Funeral director W. J. H. H. H. H. H.
Address Wadsworth, Md.19. Sept 9 47 Registrar M. L. H. H. H.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1947, at 1:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1947 to Sept 7, 1947 and that I last saw him alive on September 7, 1947

Immediate cause of death Terminal Cardiac Failure
Generalized Arteriosclerosis
 Due to Branchio-pneumonia
 DURATION 5 days
5 days

Due to _____
 Other conditions Arterial Arteriosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?23. SIGNATURE John N. Griffin M.D.
Address Hughesville, Md. Date signed Sept 8, 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:

County Charles
 City or town Morganston
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1509 Sharon Dr.
 (If rural, give LOCATION)
 2.(a) If veteran, name war #1 & #2

3. (a) FULL NAME

John E. Burns

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorcedMarried

6. (b) Name of husband or wife

Anna E. Burns
April 21, 1897 5. (c) If alive, give age 44 years
 7. Birth date of deceased (mo., day, yr.) working

8. AGE: Years 50 Months 5 Days 9 If less than one day
 :50 hrs. min.

9. Birthplace New York, N.Y. Grand Central Station
 (Town, county, and state) Calif. Spk10. Usual occupation carpenter
for Lewis R. R. Co.

11. Industry or business

12. Name John Burns13. Birthplace New York14. Maiden name Charlotte G. Frank15. Birthplace New York, N.Y.16. Informant Anna E. BurnsAddress 1509 Sharon Dr.17. Burns Date thereof Sept 30, 1947
 (Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Arleight National Cem.Location Silver Spring, Md.18. Funeral director Warner E. HumphreyAddress Silver Spring, Md.19. Sept 30, 1947 William J. Hae
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 - 1947, at 1:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from no medical treatment to 19and that I last saw him alive on 19Immediate cause of death Drowning
in Potomac River

DURATION

Due to Drowning (accident)

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9/30/47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Higgins M. D. or otherAddress Sept. 30 - Physic's Date signed 9/30/47

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY

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OCT 3 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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07942

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County CHARLES
 City or town LA PLATA
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 days
 Hospital, institution, or street address where death occurred:
Physicians' Hospital, Memorial
 How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CHARLES
 City or town BENEDICT
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

AUGUSTUS CRAIG

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

NEGRO

6. (a) Single, married, widowed, or divorced

single W

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1867

6. (c) If alive, give age _____ years

8. AGE:

80 9

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Charles Co
Rtired

10. Usual occupation

11. Industry or business

MOTHER

12. Name

Sandy Craig

13. Birthplace

Chas Co Md

14. Maiden name

15. Birthplace

16. Informant

Mary Bell

Address

Benedict Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Sept 24 1947
(month) (day) (year)

Cemetery or crematory

St Marys

Location

Bryantown Sur

18. Funeral director

Thurgood

Address

Highsville Sur

19.

9-23
(Date rec'd by registrar)19-27Julia H. Parry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1947, at LA

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-18 1947 to 9-22 1947
and that I last saw him alive on 9-21 1947

Immediate cause of death

Sarcoma of neck

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

Address

M. D. or other

Date signed 9-22-47

RECEIVED

SEP 26 1947

BUREAU # 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07943

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town La Plata Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Physician's Memorial Hospital

How long in hospital or institution?

111 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Augustus

3. (b) Social Security Number

Montgomery

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

July 21 - 1888

6. (c) If alive, give age _____ years

8. AGE:

Years 59 Months 1 Days 23 It less than one day _____ hrs. _____ min.

9. Birthplace

Waldorf Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name John Sunny Montgomery

13. Birthplace Waldorf Md

14. Maiden name Elyza Gates

15. Birthplace Waldorf Md

16. Informant

Theodore Montgomery

Address

Marbury Md

17.

(Burial, cremation, or removal, Which?)

Date the eof. 9-15-47
(month) (day) (year)

Cemetery or crematory

Cleland

Location

Waldorf Md

18. Funeral director

Hunt & Ryer

Address

Waldorf Md

19.

9-14

(Date rec'd by registrar)

19-47

John H. Rany

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 19 47 EST 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 19 44 to Sept 13 19 47 and that I last saw him alive on 9-13 19 47

Immediate cause of death

Coronary Heart Failure 6-5-47

Due to

Hypertension Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

Edell 11-1
La Plata Md
Date signed 9-13-47

Address

Date signed

MARGIN RESERVED FOR BINDING

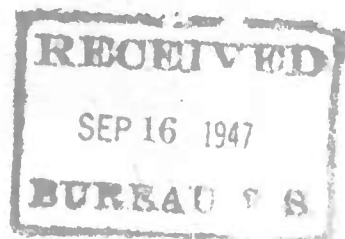
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9-45-15M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07944

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

Registrar

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH

13 September

19. 47

at 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 September

19. 47

to 13 September 19. 47

and that I last saw him alive on 13 September 19. 47

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Hypertension

Due to

Cardio-vascular disease

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. B. Woody, M.D.

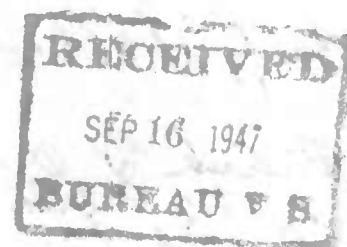
M. D. or other

Address

Box 214 La Plata, Md.

Date signed

13 Sept 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

07945

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... It less than one day..... hrs..... min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....
 13. Birthplace.....

14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....

17. Burial..... Date thereof.....
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....
 Location.....

18. Funeral director.....
 Address.....

19. 9/3..... 47.....
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him/her alive on.....
 Immediate cause of death.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Manner of injury..... Injured at work?

23. SIGNATURE.....
 Address.....
 Date signed.....

24. PHYSICIAN: Please underline the cause to which death should be charged statistically.

25. Major findings of operations.....
 Date of op.

26. Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

27. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Manner of injury..... Injured at work?

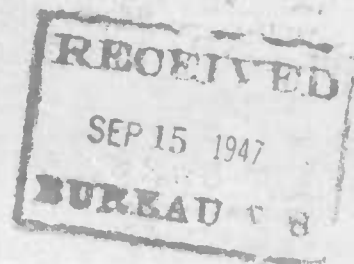
28. SIGNATURE.....
 Address.....
 Date signed.....

29. PHYSICIAN: Please underline the cause to which death should be charged statistically.

30. Major findings of operations.....
 Date of op.

31. Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

10. m
Brant Lee



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

07946

1. PLACE OF DEATH:

County..... Charles
 City or town..... Marshall Hall
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Sarah A. Slocum.

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Clarence B. Slocum

7. Birth date of deceased (mo., day, yr.)

Jan 22 1882

6.(c) If alive, give age..... years

63

8. AGE:

Years 65Months 8Days 1

If less than one day

hrs.

min.

9. Birthplace

Monticello, N. Y.
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

George S. Smith

13. Birthplace

Unknown.

MOTHER

14. Maiden name

Estherine Rouse

15. Birthplace

Sydney N. Y.

16. Informant

Clarence Slocum

Address

Marshall Hall, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

BurialShilo

Location

Bryans Road Md

18. Funeral director

Waldorf, Md.

Address

19.

(Date rec'd by registrar)

19 47Odey Price

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sep 22 1947 at 1 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19 47 to 19 47and that I last saw him/her alive on 19 47

Immediate cause of death

Diabetes Mellitus

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George O. Bicknell M.D.

M. D. or other

Address

Marlbury Md

Date signed

Sept 23 1947